ARMY EXCEPTIONAL FAMILY MEMBER PROGRAM MEDICAL SUMMARY

For use of this form, see AR 608-75; the proponent agency is OACSIM

DATA REQUIRED BY THE PRIVACY ACT OF 1974
(5 U.S.C. 552A)

AUTHORITY: PL 95-561 *(Defense Dependents' Education Act of 1978)*; PL 101-476 *(Individuals With Disabilities Education Act)*; PL 102-119 *(Individuals With Disabilities Education Act Amendments of 1991)*; DODI 1342.12 *(Provision of Early Intervention and Special Education Services to Eligible DoD Dependents in Overseas Areas)*, March 12, 1996; DODI 1010.13 *(Provision of Medically Related Services to Children Receiving or Eligible to Receive Special Education in DOD Dependents Schools Outside the United States)*, August 28, 1986; 10 USC 3013, 20 USC 921 et seq. and 1400 et seq.

PRINCIPAL PURPOSE: To obtain information needed to evaluate and document the special education and medical needs of: (1) Family members of all soldiers and (2) Family members of Department of the Army civilian employees processing for an assignment to a location outside the United States where dependent travel is authorized at Government expense.

ROUTINE USES: (1) Information will be used by personnel of the military departments to evaluate and document the special education and medical needs of family members. This information will enable --

(a) Military assignment personnel to match the needs of family members against the availability of special education and medical services.

(b) Civilian personnel offices to determine the availability of special education and medically related services to meet the needs of dependent children and medical needs of family members of Department of the Army civilian employees.

(2) Information will be used by Army Community Service in its Exceptional Family Member Outreach Program.

DISCLOSURE: The provision of requested information is mandatory. Failure to respond will preclude --

(1) U.S. Total Army Personnel Command, U.S. Army Reserve Personnel Center, and Army National Guard Readiness Center from enrolling soldiers in the Exceptional Family Member Program *(EFMP)*. Soldiers who knowingly refuse to enroll exceptional family members will receive, at a minimum, a general officer letter of reprimand. A soldier's refusal to provide information may preclude successful processing of an application for family travel/command sponsorship.

(2) Civilian personnel offices from performing required EFMP aspects of overseas processing of Department of the Army civilian employees with family members with special needs. Department of the Army civilian employees who refuse to provide information will be denied the privilege of having their family members transported to the duty assignment outside the United States at Government expense.

SECTION A - RELEASE OF INFORMATION

1. I release the information on the summary and in the attached reports to personnel of the military departments for the purpose of evaluating and documenting my family member's need for special education and medical services *(and for military personnel recommendations for my next assignment).*

2. SIGNATURE OF SPONSOR OR SPONSOR'S SPOUSE	3. DATE SIGNED *(YYYYMMDD)*

SECTION B - SPONSOR INFORMATION *(please print or type)*

4. NAME *(Last, First, MI)*	5. MILITARY DEPARTMENT AFFILIATION *(Specify if Civilian)*	
6. RANK OR GRADE	**7. PRIMARY MOS/BRANCH/CIVILIAN OCCUPATIONAL SERIES**	**8. SOCIAL SECURITY NUMBER**
9. HOME ADDRESS *(Must be a 3-line address which includes street address or P.O. Box, and Zip Code)*		**10. HOME PHONE** *(Include area code)*
11. DUTY ADDRESS *(Must be a 3-line address which includes street address or P.O. Box, and Zip Code)*		**12. DUTY PHONE** a. DSN b. COMMERCIAL *(Include area code)*
13. PROJECTED LOCATION OF NEXT ASSIGNMENT *(If known)*		**14. PROJECTED DATE OF NEXT ASSIGNMENT**

SECTION C - FAMILY MEMBER INFORMATION *(please print or type)*

15. NAME *(Last, First, MI)*	16. SEX	17. DATE OF BIRTH *(YYYYMMDD)*	18. FAMILY MEMBER PREFIX

SECTION D - MEDICAL SUMMARY

(To be completed only by a physician or other designated medical practitioner)

MEDICAL PRACTITIONER. Please fill out this form as completely and as accurately as possible. Utilize ICD 9-CM or DSM-IV, if possible. List additional diagnoses and problems under "e" Explanation below.

19. DIAGNOSES AND CARE FREQUENCY

a. CURRENT ACTIVE DIAGNOSES	b. ICD-9/DSM-IV	c. SEVERITY A - Mild B - Moderate C - Severe	d. FREQUENCY OF CARE *(Insert appppropriate letter)* Y - Yearly Q - Quarterly M - Monthly W - Weekly D - Daily N - None Use 0 thru 9 for number of times Y, Q, M, W, D, N.	
			(1) Inpatient Care	(2) Outpatient Care

e. Explanation of diagnoses that are not described exactly as the ICD-9 or DSM-IV diagnosis:

20. CARE PROVIDERS. In column a, X the **current** medical providers essential for care of the patient. Use the same frequency codes as 19d. Column 20a is a mandatory entry.

a.	CODE	TYPE	b. FREQUENCY	a.	CODE	TYPE	b. FREQUENCY
	C01	Allergist			C28	Obstetrician	
	C02	Cardiologist, General			C29	Orthodonist	
	C03	Cardiologist, Pediatric			C30	Pediatrician	
	C04	Dentist			C31	Pedodonist	
	C05	Dermatologist			C32	Physiatrist	
	C06	Developmental Pediatrician			C33	Pulmonologist	
	C07	Dietary/Nutrition Specialist			C34	Podiatrist	
	C08	Endocrinologist, General			C35	Psychiatrist, General	
	C09	Endocrinologist, Pediatric			C36	Psychiatrist, Child	
	C10	Family Practitioner			C37	Psychologist, Clinical	
	C11	Gasteroenterologist, General			C38	Psychologist, Clinical w/Child Exp.	
	C12	Gasteroenterologist, Pediatric			C39	Rheumatologist, General	
	C13	General Medical Officer			C40	Rheumatologist, Pediatric	
	C14	Geneticist			C41	Transplant Team	
	C15	Gynecologist			C42	Surgeon, Cardio-thoracic	
	C16	Hemodialysis Team			C43	Surgeon, General	
	C17	Hematologist/Oncologist, General			C44	Surgeon, Neuro	
	C18	Hematologist/Oncologist, Pediatric			C45	Surgeon, Oral	
	C19	Immunologist			C46	Surgeon, Otorhinolaryngologist	
	C20	Internist			C47	Surgeon, Orthopedic, General	
	C21	Nephrologist, General			C48	Surgeon, Orthopedic, Pediatric	
	C22	Nephrologist, Pediatric			C49	Surgeon, Pediatric	
	C23	Neurologist, General			C50	Surgeon, Plastic	
	C24	Neurologist, Pediatric			C51	Urologist	
	C25	Nuclear Medicine Physician			C52	Other *(Specify)*	
	C26	Opthalmologist, General					
	C27	Opthalmologist, Pediatric					

21. **ARTIFICIAL OPENINGS/SHUNTS** *(X all that apply)*

	CODE	TYPE		CODE	TYPE
	F01	Gastrostomy		F05	Colostomy
	F02	Tracheostomy		F06	Ileostomy
	F03	CSF Shunt		F99	Other *(Specify)*
	F04	Cystostomy			

22. **SERVICES REQUIRED** *(X all that apply)*

	CODE	TYPE		CODE	TYPE
	J01	Cognitive Enrichment Program		J10	Audiology Services
	J02	Program for Visually Impaired		J11	High Risk Newborn Follow-up Services
	J03	Social Work Services		J20	Standard Therapy for Speech/Language Impairments
	J04	Occupational Therapy		J21	Therapy for Hearing Impaired *(Includes signing)*
	J05	Community Health Nurse Services		J22	Total Communication Therapy *(Includes signing for hearing persons)*
	J06	Program for Oral Motor RX		J23	Augmentative Speech Therapy *(Uses Communication Devices)*
	J07	Apnea Monitor Home Program		J24	Alaryngeal Speech Therapy *(Rehabilitation after laryngeal surgery)*
	J08	Physical Therapy		J99	Other *(Specify)*
	J09	Community Mental Health Services			

23. **ADAPTIVE EQUIPMENT NEEDS** *(X all that apply)*

	CODE	TYPE		CODE	TYPE
	L01	Ambulatory Aids		L08	Wheelchair *(Manual)*
	L02	Communication Aids		L09	Cardiac Pacemaker
	L03	Apnea Monitor		L10	Wheelchair *(Electric)*
	L04	Hearing Aids/Auditory Trainer		L11	Augmentative Speech Aids
	L05	Artificial Limbs		L12	Home Oxygen Therapy
	L06	Respiratory Aids		L99	Other *(Specify)*
	L07	Braces/Splints			

24. ARCHITECTURAL CONSIDERATIONS *(X if applicable)* ☐ Limited Steps ☐ Complete Wheelchair Accessibility

25. MEDICATIONS *(List all medications required by the patient on a routine basis, including chemotherapy, radiation therapy, psychotropics and blood products. This block must be filled in with either medication or none.)*

26. Has this patient had cancer or leukemia in the past? ☐ YES ☐ NO

If yes, this patient has been disease-free for _____ years and has a _____ % chance of remaining disease-free.
The above statement should be completed only by a physician knowledgeable about the disease and its prognosis.

27. TREATMENT PLANNED *(Describe treatment or surgery planned or likely within the next 3 years, including expected duration. List any other problems or family circumstances that should be considered in the assignment of the sponsor. This block should be filled out in detail for any chronic disorder requiring weekly to monthly care or more than four specialists yearly.)*

28. HAS THERE BEEN INTENSIVE MENTAL HEALTH CARE WITHIN THE LAST 5 YEARS? *(If yes, explain inpatient and/or outpatient care with emphasis on clinical course, compliance, prognosis, and participation of family members in treatment.)* ☐ YES ☐ NO

29. FUNCTIONAL DISABILITY SCALE

INSTRUCTIONS

1. The functional disability scale should be completed by the practitioner after discussion with the family member and review of medical records.

a. The functional disability scale records the impact the patient's disease process or disability is having on selected activities of daily living. These activities are listed as:

(1) Bathing, dressing, eating. This reflects ability to care for one's self in a manner appropriate for one's age.

(2) Quiet activity such as reading, playing a board game, doing handwork.

(3) Vigorous activity such as gym class in school, organized sports, hiking, etc.

(4) School or work. This reflects endurance and absences due to illness.

(5) Sleep. This reflects the frequency with which sleep is disrupted by the illness or disability.

(6) Socialization with peers such as conversations, going to the movies with one's peers, attending parent groups, etc.

b. The level of disability indicates the extent to which the activity is constrained or impacted by the illness or disability.

(1) None means none.

(2) Partial means the disability partly, but not completely, prevents or impacts the activity.

(3) Total means the disability totally prevents the activity from occurring.

c. Equipment assistance indicates those activities that are possible or greatly improved with the use of adaptive equipment or durable medical equipment. Examples would be a forearm prosthesis assisting with bathing, dressing, and eating, sleeping assisted with nasal prong oxygen, or a communication board assisting with socialization with peers.

d. Frequency of interference asks you to estimate how often the activity is compromised by the illness or disability.

2. The scale should reflect the ability of the patient to engage in the activities in comparision to his or her same aged, non-disabled peers. For instance, if 2-month-old infant has an illness that is *not impacting* his or her ability to eat in a manner comparable to non-disabled peers, that child would have "none" listed for level of disability under "bathing, dressing, eating" even though the infant is not independent in those activities.

a. Activity	b. Level of Disability *(Enter N - None, P - Partial, T - Total)*	c. Equipment *(Enter N - Not Used, U - Used)*	d. Frequency of Interference *(Enter appropriate letter and number: Y - Yearly, Q - Quarterly, M - Monthly, D - Daily, N - N/A. Use 0 - 9 for number of times Y, Q, M, D)*
(1) Bathing, Dressing, Eating			
(2) Quiet Activity			
(3) Vigorous Activity			
(4) School or Work			
(5) Sleep			
(6) Socialization with Peers			

SECTION E - ACKNOWLEDGEMENTS

30. **PATIENT OR SPONSOR**:
The above medical information has been reviewed and found to be accurate and complete.

a. SIGNATURE	b. DATE SIGNED *(YYYYMMDD)*

31. **MEDICAL PRACTITIONER**

a. TYPED OR PRINTED NAME OF MEDICAL PRACTITIONER COMPLETING THE DA FORM 5862-R	b. TELEPHONE NUMBER (1) DSN
c. ADDRESS OF MEDICAL PRACTITIONER *(Include Zip Code)*	(2) COMMERCIAL *(Include area code)*
d. SIGNATURE OF MEDICAL PRACTITIONER	e. DATE SIGNED *(YYYYMMDD)*

f. **PHYSICIAN'S AUTHENTICATION** *(To be signed when a medical practitioner other than a physician completes the DA Form 5862-R)*

g. TYPED OR PRINTED NAME OF PHYSICIAN	h. RANK OF PHYSICIAN *(typed or printed)*
i. TITLE OF PHYSICIAN *(typed or printed)*	j. GRADE OF PHYSICIAN *(typed or printed)*
k. SIGNATURE OF PHYSICIAN	l. DATE SIGNED *(YYYYMMDD)*

32. FOR USE BY MEDICAL COMMAND AND ASSIGNMENT PERSONNEL ONLY

33. FOR USE IN THE EFMP CODING PROCESS

a. Child is in residential treatment facility receiving medical care not available overseas; assign with individual case consideration. ☐ YES ☐ NO

b. Please enter disenrollment code *(if applicable):* D - Death E - Educational condition no longer exists M - Medical condition no longer exists N - No longer meets requirements S - Separation/Retirement V - Divorce

c. NAME OF CODER *(Last, first, middle initial)*	d. MEDICAL TREATMENT FACILITY CODE